HHSC: Perinatal Advisory Council, November 17th, 2020

The Perinatal Advisory Council develops and recommends criteria for designating levels of neonatal and maternal care.

The Perinatal Advisory Council, created by House Bill 15 of the 83rd Texas Legislature (Regular Session), develops and recommends criteria for designating levels of neonatal and maternal care, including specifying the minimum requirements to qualify for each level designation and a process for the assignment of levels of care to a hospital, makes recommendations for dividing the state into neonatal and maternal care regions, examines utilization trends in neonatal and maternal care, and recommends ways to improve neonatal and maternal outcomes.

House Bill 3433 of the 84th Texas Legislature (Regular Session) amended House Bill 15 by adding two new members to the Perinatal Advisory Council and extended the date of its report. The council must submit a report with its recommendations to the Health and Human Services Commission and the Department of State Health Services by September 1, 2016.

Dr. Emily Briggs, Chair Family medicine physician who provides obstetrical care in a rural community New Braunfels	**Dara Lankford, RN** Nurse with expertise in perinatal health Ft. Worth
Dr. Cynthia Blanco, Co-chair Neonatologist in Level III or IV NICU San Antonio	**Dr. Alyssa Molina** Family medicine physician who provides obstetrical care in a rural community Eagle Lake
Dr. Andy Bowman Neonatologist from rural area Midland	**Dr. Patrick Ramsey** Maternal fetal medicine San Antonio
Dr. Sadhana Chheda Neonatologist in Level III or IV NICU El Paso	**Karen Rhodes, RN** Nurse with expertise in maternal health Brownsville
Stephanie Ferguson, RN Rural Hospital representative Childress	**Saundra Rivers, RN** Rural Hospital Representative Sweetwater
Dr. Ryan Van Ramshorst Ex-officio Austin	**Dr. David B. Nelson** Maternal fetal medicine Dallas
Dr. Alice Gong General hospital representative San Antonio	**Dr. Michael Stanley** Neonatologist Richardson
Dr. Charleta Guillory Pediatrician Houston	**Dr. Eugene Toy** Obstetrics-gynecology Houston
Allen Harrison Representative from a hospital with Level II NICU Austin	**Ms Patricia Carr** Children's hospital representative Corpus Christi
Dr. Lisa Hollier Obstetrics-gynecology Houston	

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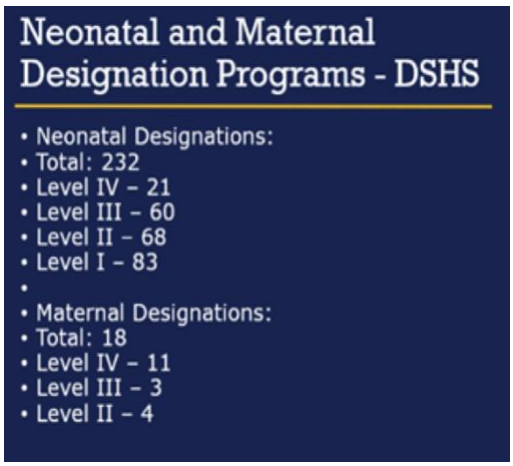
1. Welcome, logistical announcement and roll call. The meeting was convened by the Chair, Dr. Briggs. A quorum was present.

2. Approval of the June 16, 2020, and September 15, 2020, meeting minutes. The minutes from both meetings were approved as written.

3. Neonatal and maternal designation programs. Department of State Health Services (DSHS).



- Total Maternal Applications Received: 85
- Designated: 18
- Remaining Applications: 67
- Processing Recommendations: 56
- Requiring Clarification from Hospital or Survey Organization: 4
- In Review: 4
- Incomplete Applications: 3
- The 56 recommendations will be completed by December 1st.
- The Designation Coordinators will be contacting hospitals in the next few weeks to schedule conference calls regarding their designation determination.
- Total Virtual Surveys for Neonatal and Maternal: 14
- Centers of Excellence for Fetal Diagnosis and Therapy Survey Process hopefully for release in the fall of 2021
- Strategic Review of the Practical Implementation of Maternal Designations Report (will be delayed until designations are completed)
- Neonatal and Maternal Rule Revision

Due to COVID-19, two facilities requested an exception that will remain in place until the emergency status is lifted. If you need an extension, there is a process and you should contact designation coordinators.

Q: Why are there differences in the designations? HHSC stated that is because they have until the end of May 2021. COVID-19 has delayed the process. The maternal number will be about six (6) less than neonatal. The deadline is legislatively mandated.

Q: Where is the link to look up a specific facility? HHSC stated to go to the DSHS website for a list of designated facilities.

Q: Who is doing the designation for fetal diagnosis and surgery? Performance improvement has been an issue. A power point has been developed and there are terms that need definition. This group should define the elements for the performance improvement process. Content reviewers were requested.

C: We have to develop formalized metrics based on hospital data.

4. Best Practices - Perinatal Care Regions on Quality Assessment and Performance Improvement Program.

The Texas Perinatal Care Regions (PCR's) have been charged with collaborative QI based upon the Texas Level of Care Designation Guidelines. The Texas PCR's formed a collaborative group, known now as the Regional Advisory Council – Perinatal Care Region Alliance (RAC-PCR Alliance) in 2017. In late 2019, the RAC-PCR Alliance was also integrated into the Texas Collaborative for Healthy Mothers and Babies. TCHMB is the Perinatal Quality Collaborative for the State of Texas – Neonatal, Obstetrics, Community Health, and Data Committees. The RAC-PCR Alliance now serves as liaison to the hospital stakeholder effectors for TCHMB projects, acts as a liaison to the PAC/DSHS for issues and concerns regarding LOC designation, and encourages local PCR and statewide PCR collaboration to improve maternal and neonatal care.

As early as 1976, the Committee of Perinatal Health with members of March of Dimes, American Academy of Family Practice (AAFP), American Academy of Pediatrics (AAP), American Committee of Gynecology (ACOG), and American Medical Association (AMA) introduced the concept of perinatal regionalization as a strategy to improve pregnancy outcomes. Regionalization of health care is a method to provide high quality, cost-efficient health care to the largest number of patients. Regionalization of care improves health care by:

- Allowing high acuity patients to receive care at facilities with necessary resources
- Improving systems of care through coordination of care and education

In 2016, the Department of State Health Services in Texas implemented state designations for NICUs and established 22 Perinatal Care Regions each with a Perinatal Committee that focused on QI projects.

The Perinatal Committee of North Central Texas Trauma Regional Advisory Council (NCTTRAC) includes 54 hospitals that provide maternal and neonatal care with goals to standardize QI data processes.

Many states have utilized regionalization to establish Quality Improvement projects and have been successful in areas such as improving outcomes in ELBW infants born at 22-26 weeks and reducing CLABSI rates. Our first QI project was the optimization of newborn admission

temperatures. Both hypothermia and hyperthermia in the newborn are known to increase morbidity and mortality, especially in preterm infants.

Objective: To use state-mandated regionalization of care to establish best practice guidelines to decrease hypothermia on admission to NICUs and MBUs by 20% without increasing hyperthermia over a 3-year period. The Perinatal Committee of NCTTRAC aim to standardize the collection of admission temperatures in all newborns.

Methods:

- Hypothermia (<36.0°C) and Hyperthermia (>37.5°C) were defined using WHO criteria.
- The Perinatal Committee of NCTTRAC held monthly meetings to share best practices and established a standardized temperature guideline.
- Temperature was recorded on admission to NICU and within 20-60 min of life in MBU.
- Quarterly surveys sent via the regional listserv were used to obtain de-identified data on number of admissions to NICU/MBU, number of infants with hypo/hyperthermia on admission, method for obtaining temperature, and whether a temperature policy was established in respective hospitals.
- Control charts were used to determine rate changes in hypo- and hyperthermia

Hypothermia and Hyperthermia Rates in the NICU (N=37,968)

	Q0	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12
Total	4397	2986	3101	3111	3337	2880	2400	2900	2725	2043	2171	2950	2967
Total Hypothermia	148	88	79	80	77	66	50	48	53	55	40	40	60
Total Normothermia	3880	2447	2852	2868	3249	2696	2241	2739	2559	1913	2043	2693	2750
Totala Hyperthermia	369	184	170	165	181	118	109	118	139	75	88	217	157
% Hospitals with policies	63.6%	63.6%	75.0%	82.9%	87.5%	96.8%	96.8%	90.9%	93.1%	95.8%	96.6%	100.0%	97.1%
% Hospitals using Axillary Temp	69.7%	69.7%	72.2%	71.4%	81.3%	77.4%	77.4%	84.8%	82.8%	83.3%	82.8%	90.0%	88.2%
# of NICUs reporting	33	33	36	35	32	31	31	33	29	24	29	30	34
% Hypothermia	3.37%	2.95%	2.55%	2.57%	2.31%	2.29%	2.08%	1.66%	1.94%	2.69%	1.84%	1.36%	2.02%
% Hyperthermia	8.39%	6.16%	5.48%	5.30%	5.42%	4.10%	4.54%	4.07%	5.10%	3.67%	4.05%	7.36%	5.29%

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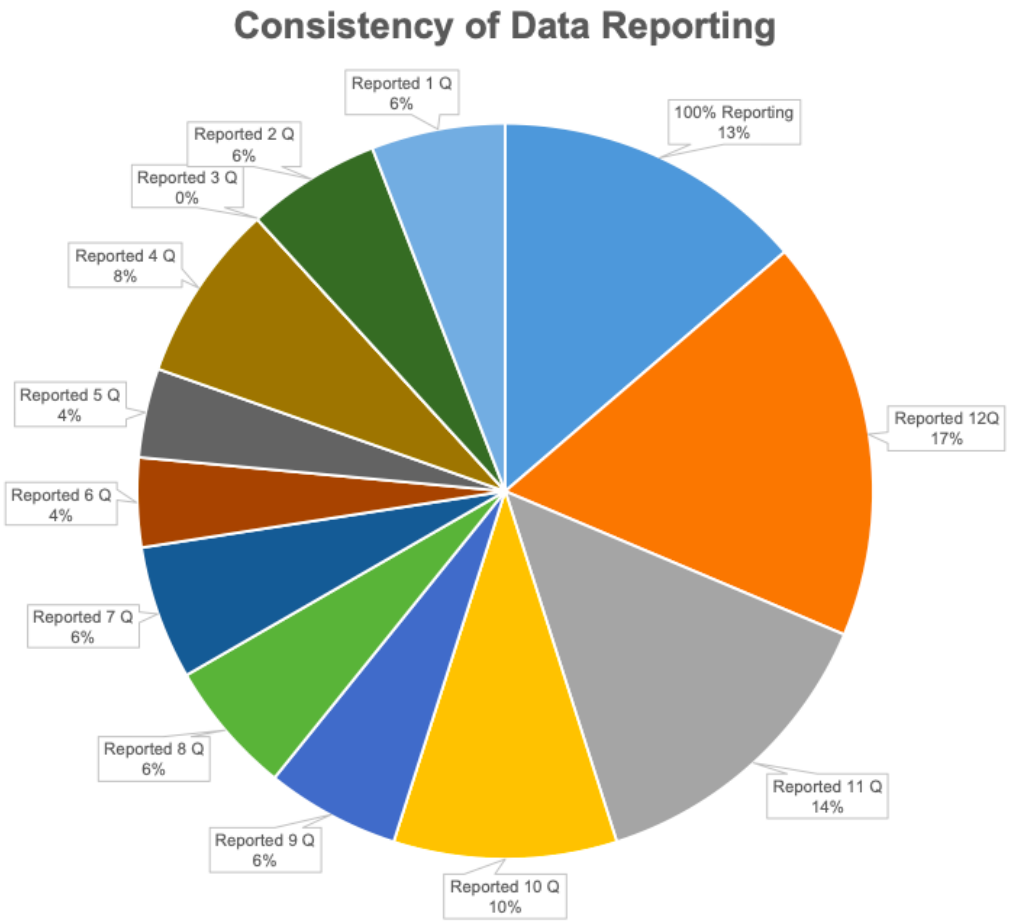
Hypothermia and Hyperthermia Rates in MBUs (N=237,800)

	Q0	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12
Total	25750	17710	19585	20612	20489	17872	16220	18499	16189	12816	14426	18836	18796
Total Hypothermia	325	206	173	170	165	154	142	147	143	106	142	159	137
Total Normothermia	22581	15852	18467	19194	18939	16512	15114	17356	14947	12129	13761	17862	17882
Totala Hyperthermia	2002	1269	945	1248	1385	1206	964	996	1099	582	533	815	777
% Hospitals with policies	64.7%	60.6%	73.0%	83.3%	87.9%	96.9%	93.9%	88.6%	93.3%	92.6%	93.3%	97.0%	94.7%
% Hospitals using Axillary Temp	79.4%	72.7%	73.0%	80.6%	84.8%	81.3%	87.9%	85.7%	83.3%	92.6%	86.7%	97.0%	92.1%
# of NICUs reporting	34	33	37	36	33	32	33	35	30	27	30	33	38
% Hypothermia	1.26%	1.16%	0.88%	0.82%	0.81%	0.86%	0.88%	0.79%	0.88%	0.83%	0.98%	0.84%	0.73%
% Hyperthermia	7.77%	7.17%	4.83%	6.05%	6.76%	6.75%	5.94%	5.38%	6.79%	4.54%	3.69%	4.33%	4.13%



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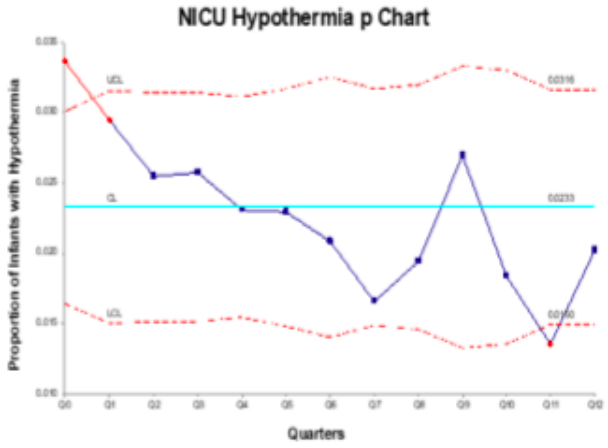
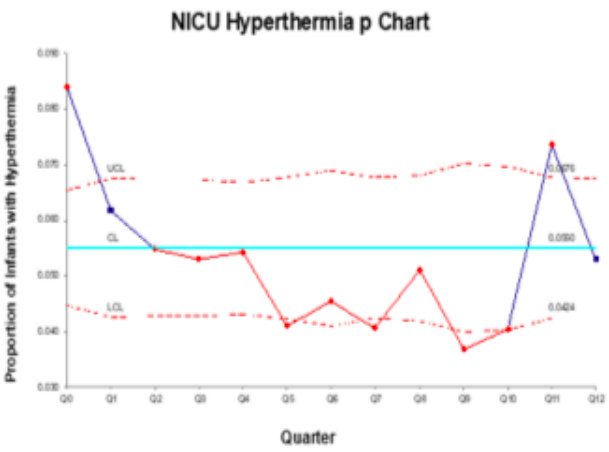
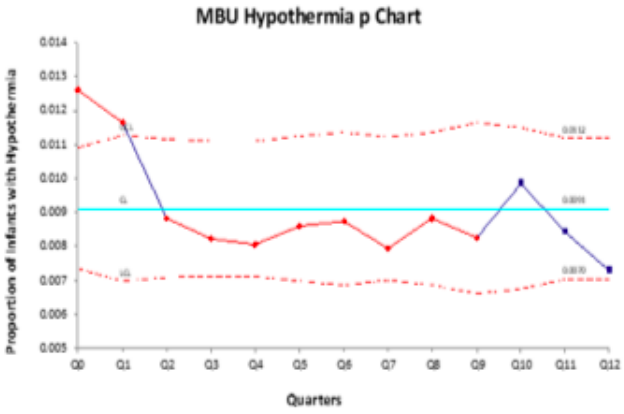
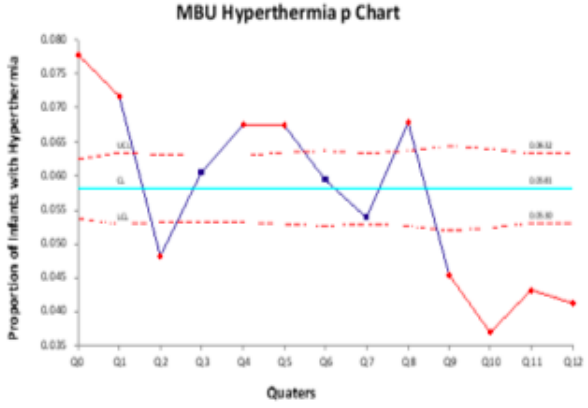




For hypothermia, linear trend analysis P-value was < 0.01 in the NICU and reached statistical significant by quarter 4. While there is an acute increase in hypothermic infants in Q9, it seems like the data is trending back down again.
For hyperthermia, the linear trend analysis P-value in the NICU was < 0.01.

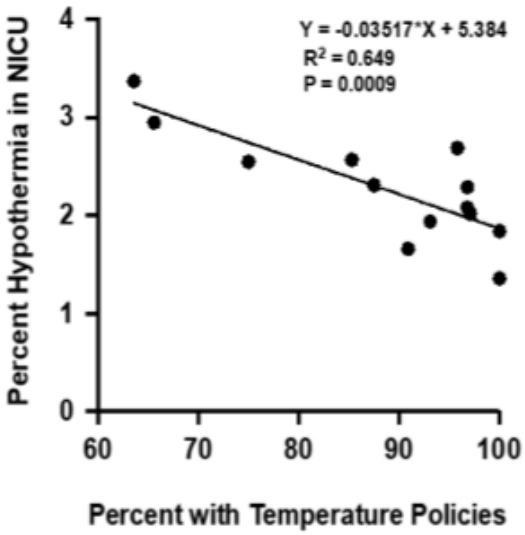


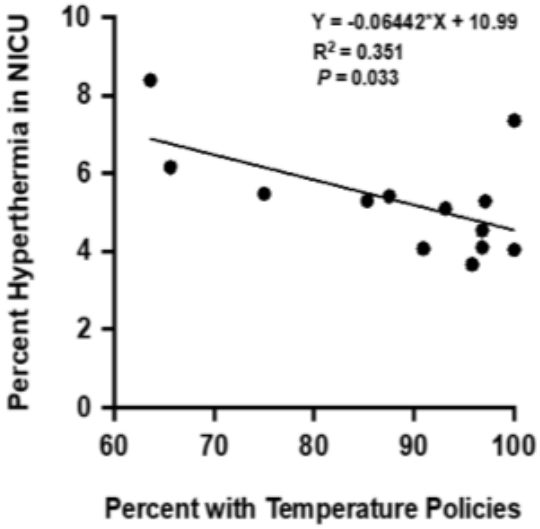


For both hypothermia and hyperthermia, there is a statistically significant shift in baseline rate.

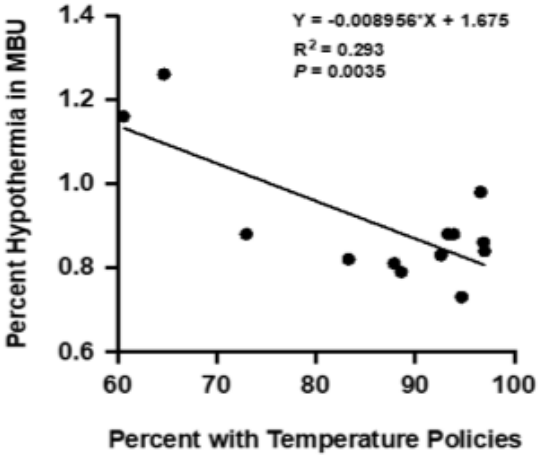
The linear trend analysis P-value for hypothermia was < 0.03 and hyperthermia was < 0.01.

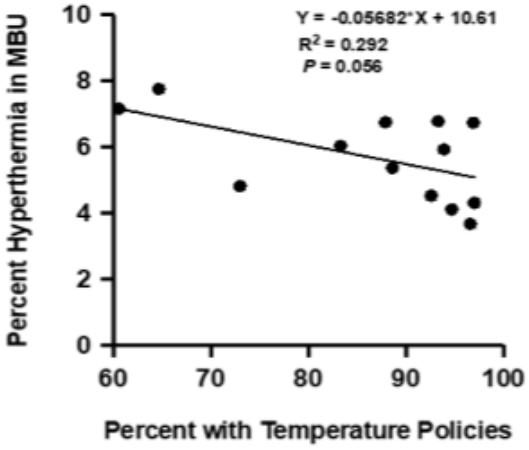
Correlation between the establishment of hospital temperature policies and the rates of hypothermia and hyperthermia in the NICU



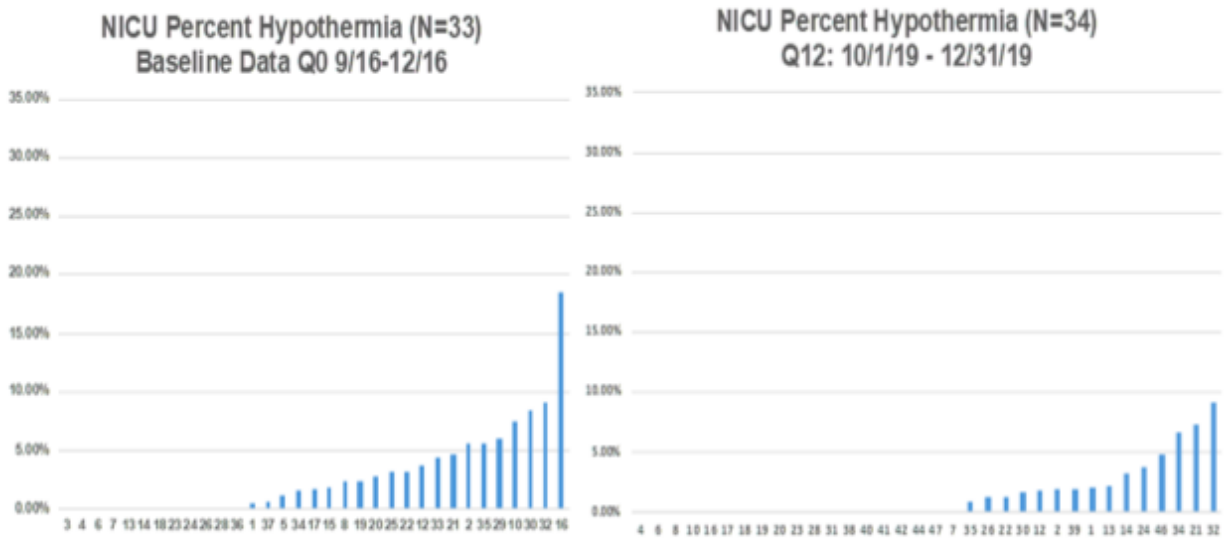


Correlation between the establishment of hospital temperature policies and the rates of hypothermia and hyperthermia in MBUs

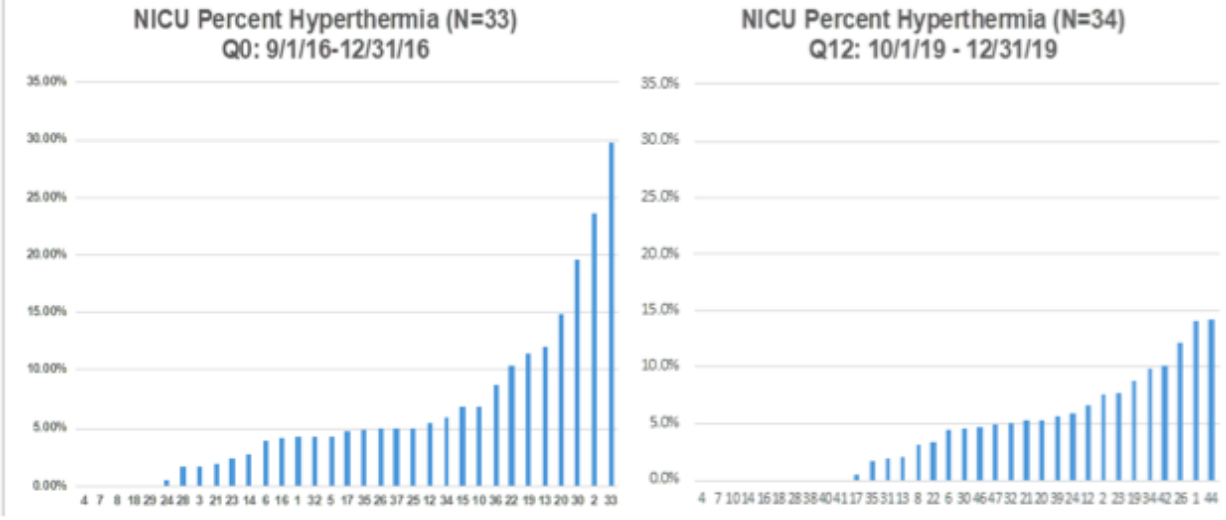




Interhospital Variability – NICU Hypothermia



Interhospital Variability – NICU Hyperthermia



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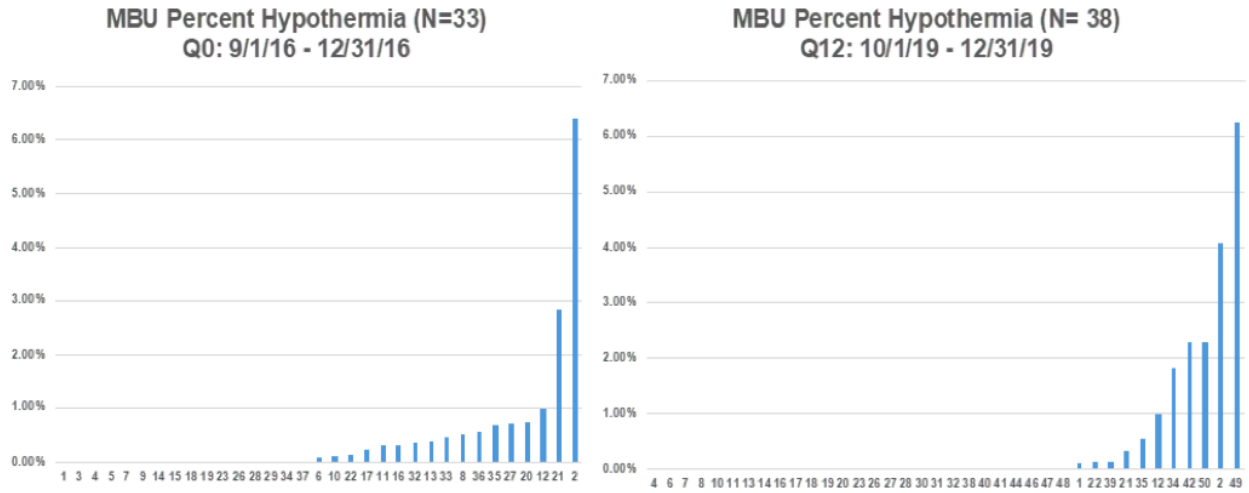
Interhospital Variability – MBU Hypothermia



One of the benefits of a regionalized QI study is the large population size. In total, 37,968 of NICU and 237,800 of MBU admissions were tracked in this study. Each quarter, the response rate was ~60% of 54 hospitals. Monthly meetings focusing on best practices and standardizing a hospital policy was beneficial irrespective of the level of the unit. Control charts showed significant decrease in rates of hypothermia on admission to both NICU ($P<0.01$) and MBU ($P<0.03$) over the 3-year period. Statistical significance was reached by the 4th quarter.

This improvement was seen with a concurrent increase in establishment of newborn temperature guidelines in participating hospitals from 64% to 97%.

Importantly, as a balancing measure, there was no increase in hyperthermia on admission to NICU or MBU. In fact, hyperthermia also significantly decreased ($P<0.01$).

While regional collaboration can increase the patient pool being studied, it also has limitations. Information is limited to the proposed survey and relies on individual hospital to input data consistently. Information on demographics of the patient population and other cofounding factors are limited.

Conclusion: Regionalization of care with standardized approaches to newborn temperature significantly decreased rates of hypo-and hyperthermia on admission to the NICU and MBU, in association with increased adoption of temperature guidelines. This initiative is now being expanded to all 22 perinatal regions in Texas.

The SETRAC Perinatal Committee

4 Workgroups

- Perinatal Quality Improvement/Quality Measures
- Maternal Morbidity and Mortality
- Low Birth Weight Infant Morbidity
- Perinatal Planning

SETRAC Perinatal QI and QI Measures Workgroup--

- SETRAC Perinatal Database with Data dictionary, now quarterly web-based data entry, FAQ document for data collection. 100% participation of level 2-4 NICUs since 2018! (see upcoming slides)
- Maternal Quality Measures Project
- Antibiotic Timeliness Project
- Breastmilk at NICU Discharge Project
- Neonatal and Maternal Program Manager Collaborative – COVID Updates
- Maternal Depression Screening Project
- Neonatal Resuscitation for EMS Project (2021)
- TCHMB Neonatal Admission Temperature Project Team
- RAC-PCR Alliance NICU Neuroimaging Project Team (2021)

Summary of SETRAC Data Collection

- Collection of data began with January 2018 data via Excel spreadsheets. The data points went through a series of revisions and was finalized and fully implemented beginning with January 2019 data.
- Data submissions have been received from 34 hospitals in the SETRAC region (Level II, III, and IV designated facilities.)
- A secure online database website was created to allow hospitals to input, view, and revise submitted data.
- Aggregate data initially was submitted twice a year. Data is now submitted quarterly (broken down by months.)

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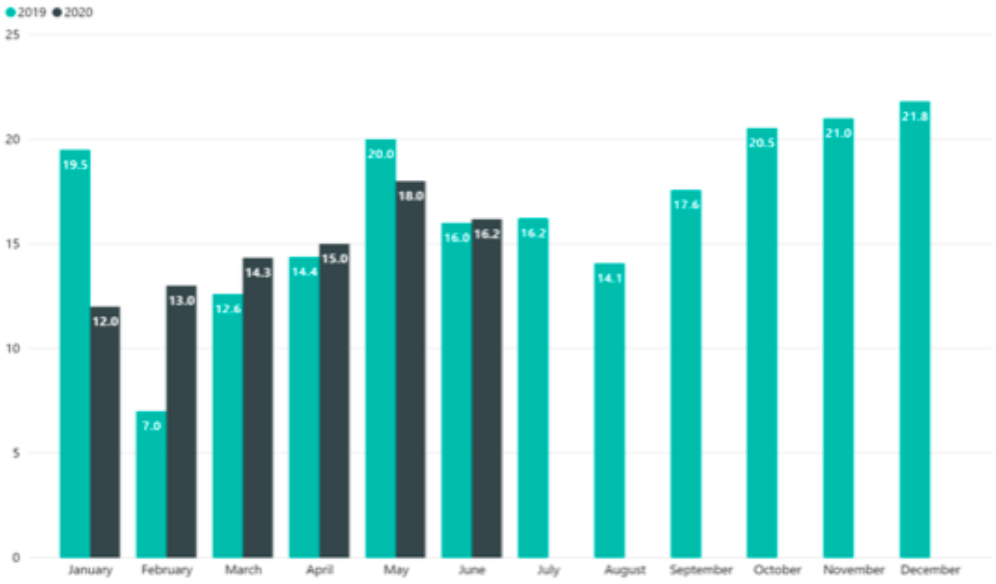
Neonatal Data - 2019-2020

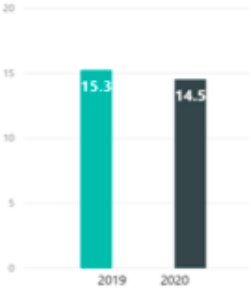
Median of LOS Very Low Birth Weight by Month



Total Inborn VLBW pts

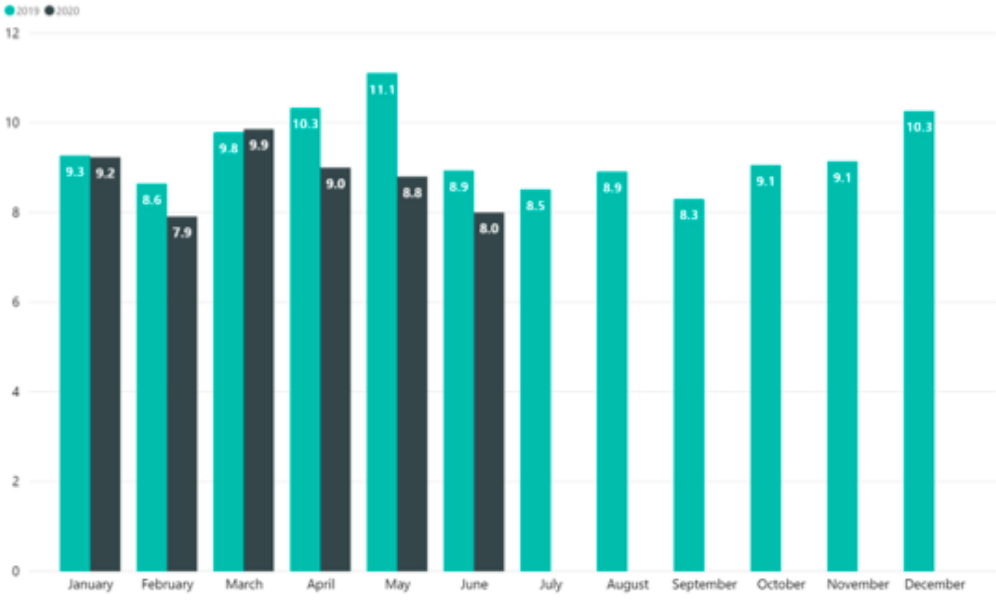
Month	2019	2020
January	121	156
February	113	120
March	136	105
April	129	106
May	115	139
June	132	162
July	158	
August	158	
September	144	
October	146	
November	135	
December	128	
Total	1615	788

Median by Year (Jan-Jun)



Neonatal Data - 2019-2020

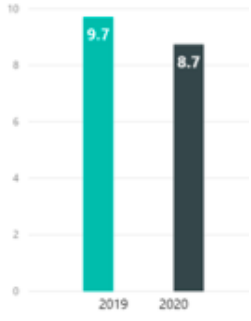
Median of LOS Late Preterm Infants by Month



Total Inborn LPI pts

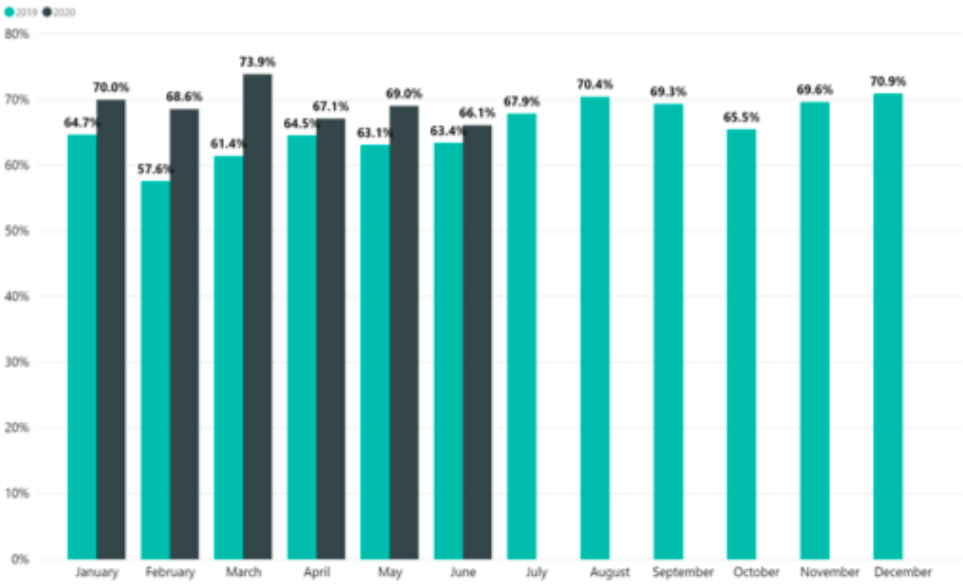
Month	2019	2020
January	315	347
February	337	378
March	338	348
April	346	344
May	278	312
June	342	380
July	391	
August	396	
September	366	
October	390	
November	381	
December	384	
Total	4264	2109

Median by Year (Jan - Jun)



Neonatal Data - 2019-2020

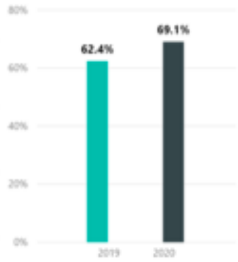
Average % of Babies Discharged on Breastmilk (NICU)



Total Inborn and Outborn NICU D/C

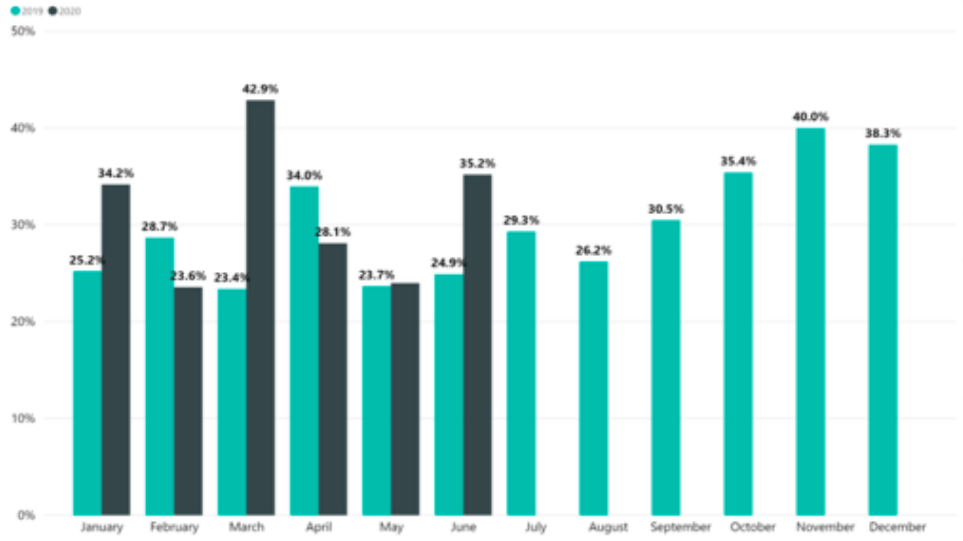
Month	2019	2020
January	976	956
February	906	948
March	1033	1083
April	1032	947
May	1011	999
June	1022	1083
July	1189	
August	1184	
September	1163	
October	1207	
November	1079	
December	1115	
Total	12917	6016

Average by Year (Jan - Jun)



Neonatal Data - 2019-2020

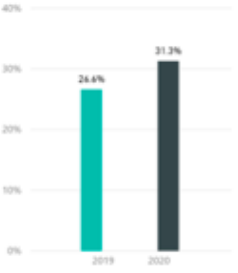
Average % of Babies Discharged on Breastmilk (VLBW)



Total Inborn and Outborn VLBW D/C from NICU

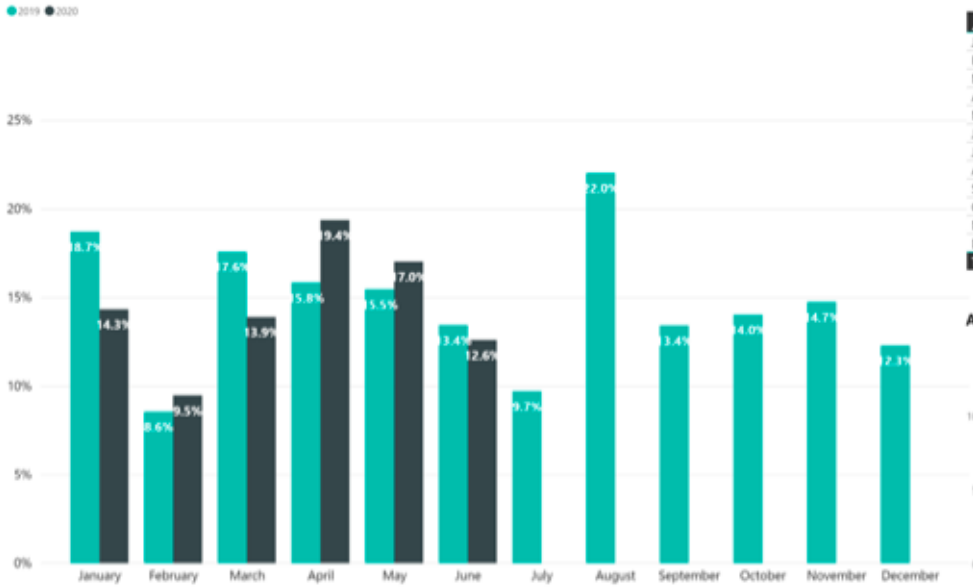
Month	2019	2020
March	84	95
June	82	92
January	79	86
May	73	79
April	91	76
February	71	70
July	101	
August	85	
September	96	
October	91	
November	100	
December	80	
Total	1033	498

Average by Year (Jan - Jun)



Neonatal Data - 2019-2020

Babies < 33 weeks at birth admitted to NICU with temp <36.5 degrees



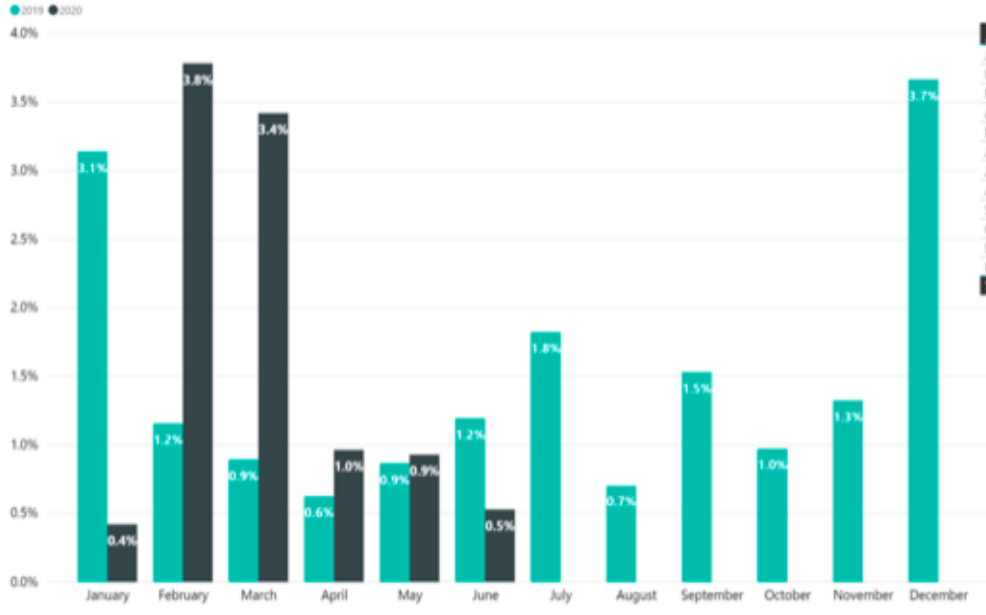
Total Number of Babies <33 Weeks Born in Reporting Hospital

Month	2019	2020
January	146	160
February	144	163
March	181	108
April	160	123
May	162	156
June	181	132
July	198	
August	178	
September	200	
October	167	
November	156	
December	160	
Total	2033	842

Average by Year (Jan - Jun)

Neonatal Data - 2019-2020

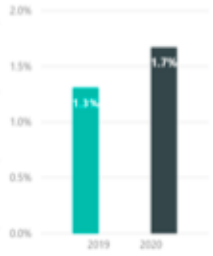
Infection Reporting --> Positive Neonatal Bloodstream Infections

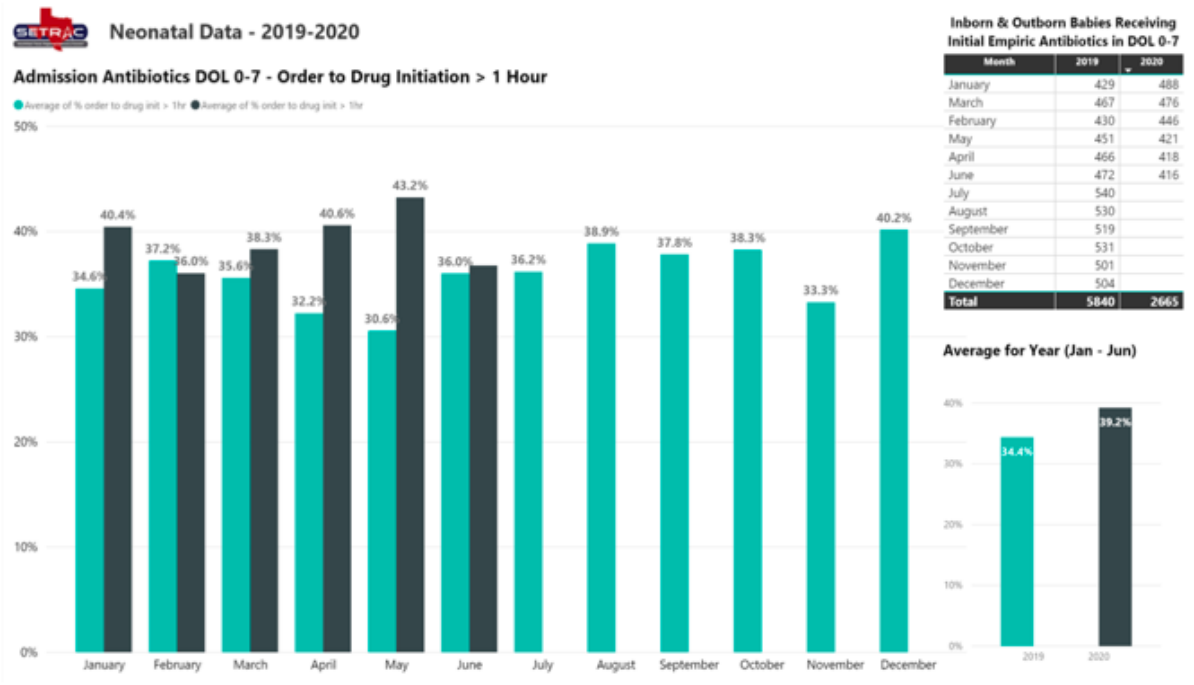


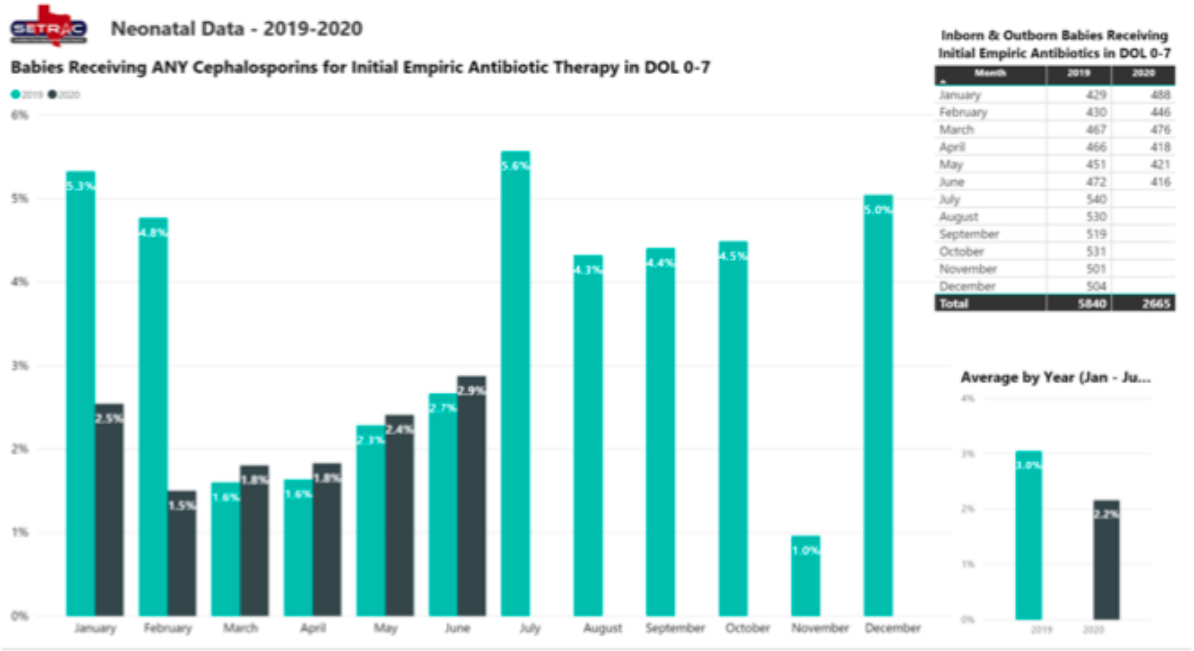
Total Inborn & Outborn Admitted NICU Babies

Month	2019	2020
January	1098	1123
February	1035	1040
March	1143	1046
April	1109	1009
May	1083	1054
June	1183	1115
July	1272	
August	1300	
September	1190	
October	1220	
November	1093	
December	1188	
Total	13914	6387

Average by Year (Jan - Ju...




Neonatal Data - 2019-2020
Admission Antibiotics DOL 0-7 - Order to Drug Initiation > 1 Hour
Average of % order to drug init > 1hr
Average of % order to drug init > 1hr
50%
40%
30%
20%
10%
0%
34.6%
40.4%
37.2%
36.0%
35.6%
38.3%
32.2%
40.6%
30.6%
43.2%
36.0%
36.2%
38.9%
37.8%
38.3%
33.3%
40.2%
January
February
March
April
May
June
July
August
September
October
November
December
Inborn & Outborn Babies Receiving Initial Empiric Antibiotics in DOL 0-7
Month 2019 2020
January 429 488
March 467 476
February 430 446
May 451 421
April 466 418
June 472 416
July 540
August 530
September 519
October 531
November 501
December 504
Total 5840 2665
Average for Year (Jan - Jun)
40%
30%
20%
10%
0%
34.4%
39.2%
2019
2020


Neonatal Data - 2019-2020
Babies Receiving ANY Cephalosporins for Initial Empiric Antibiotic Therapy in DOL 0-7
2019 2020
6%
5%
4%
3%
2%
1%
0%
5.3%
2.5%
4.8%
1.5%
1.6%
1.8%
1.6%
1.8%
2.3%
2.4%
2.7%
2.9%
5.6%
4.3%
4.4%
4.5%
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January
February
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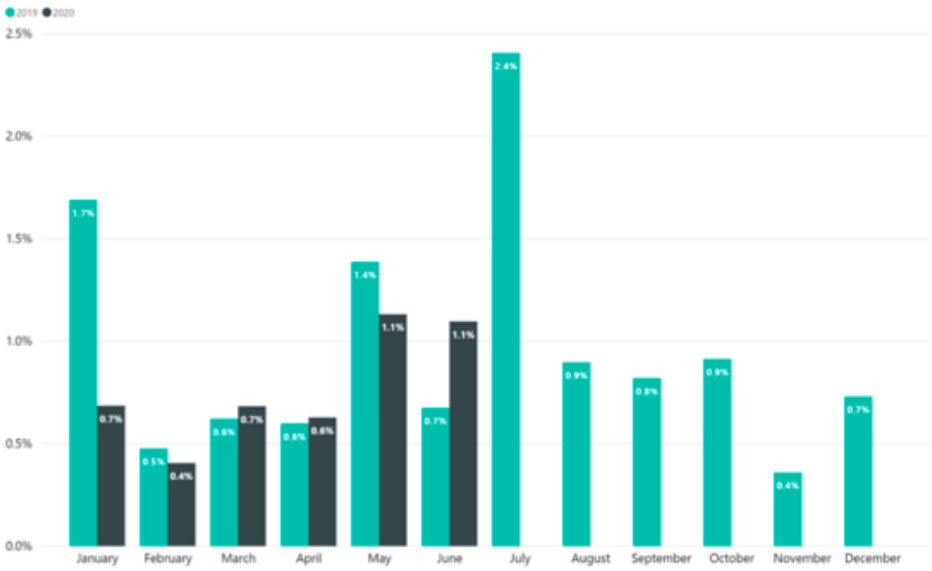
May 451 421
June 472 416
July 540
August 530
September 519
October 531
November 501
December 504
Total 5840 2665
Average by Year (Jan - Ju...
4%
3%
2%
1%
0%
3.0%
2.2%
2019
2020

Neonatal Data - 2019-2020

NICU Mortality



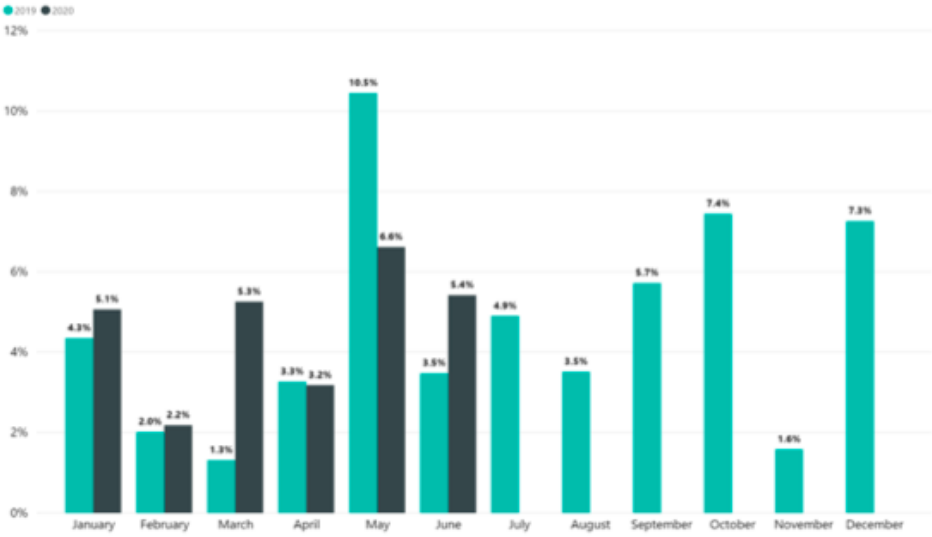
Total Admitted NICU Babies

Month	2019	2020
January	1098	1123
February	1035	1040
March	1143	1046
April	1109	1009
May	1083	1054
June	1183	1115
July	1272	
August	1300	
September	1190	
October	1220	
November	1093	
December	1188	
Total	13914	6387

Average by Year (Jan - Jun)

Neonatal Data - 2019-2020

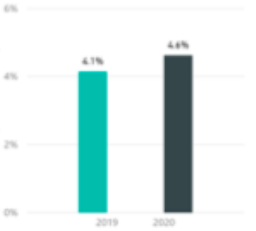
VLBW Total Mortality Percentages



Total Admitted VLBW Neonates

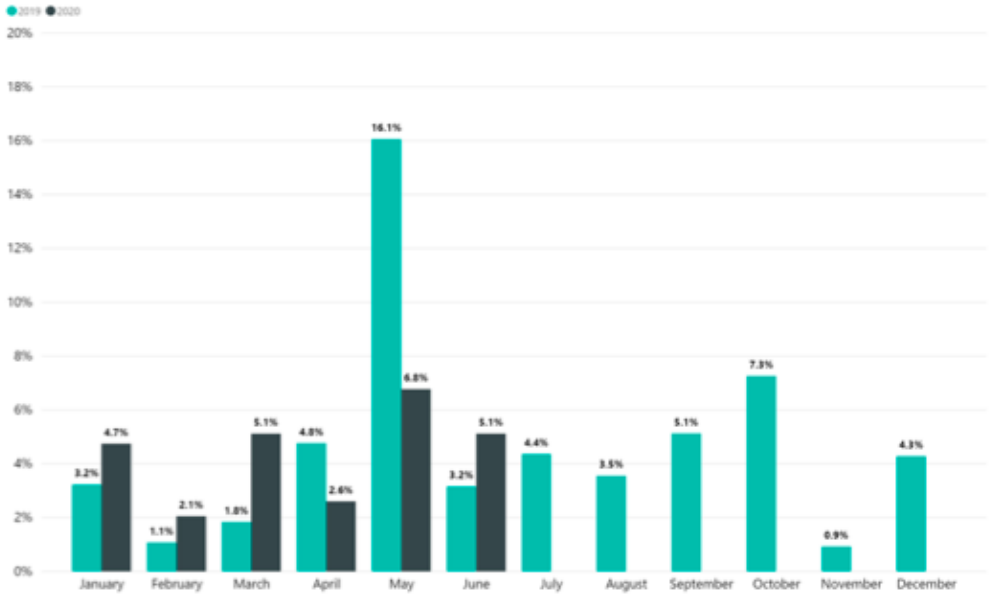
Month	2019	2020
January	138	158
February	122	125
March	158	108
April	140	110
May	132	143
June	144	171
July	169	
August	172	
September	151	
October	151	
November	149	
December	136	
Total	1762	815

Average by Year (Jan - Jun)



Neonatal Data - 2019-2020

VLBW Mortality Percentages (Inborn Patients)



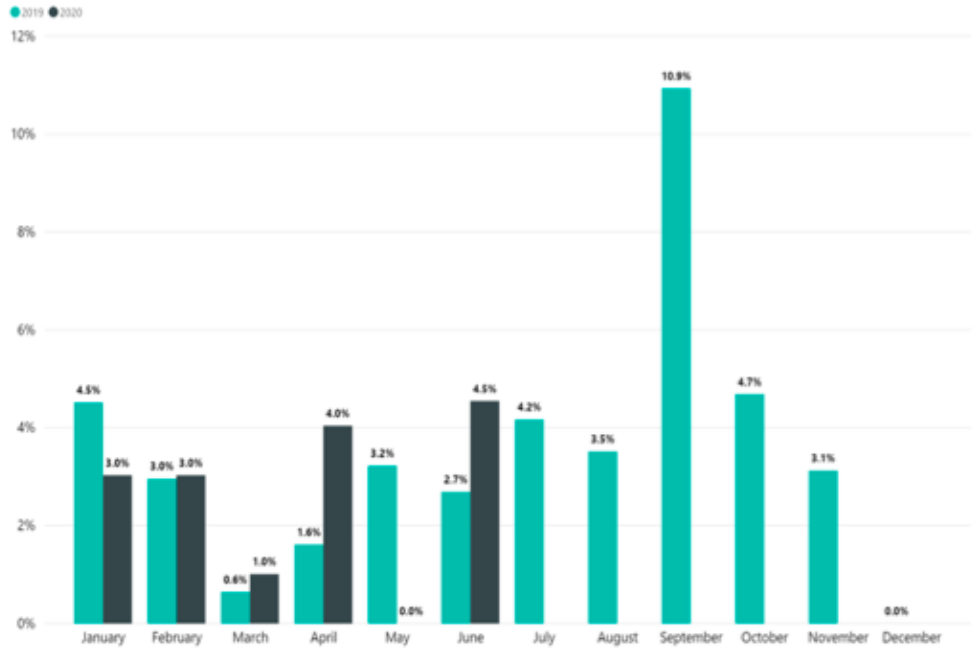
Total Inborn VLBW Neonates

Month	2019	2020
January	121	156
February	112	120
March	136	105
April	129	106
May	115	139
June	132	162
July	158	
August	158	
September	144	
October	146	
November	135	
December	128	
Total	1614	788

Average by Year (Jan - Jun)

Neonatal Data - 2019-2020

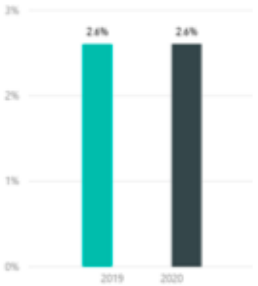
VLBW Outborn Mortality Percentages



Outborn Neonates Transferred Into and Admitted by Center

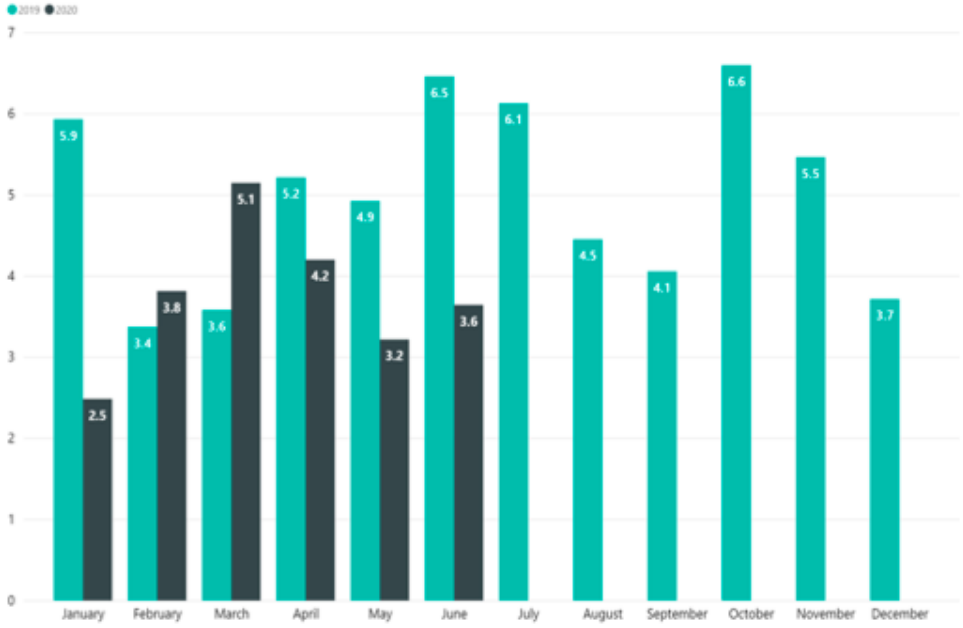
Month	2019	2020
January	17	2
February	10	5
March	22	3
April	11	4
May	17	4
June	12	9
July	11	
August	14	
September	7	
October	5	
November	14	
December	8	
Total	148	27

Average by Year (Jan - Jun)



Neonatal Data - 2019-2020

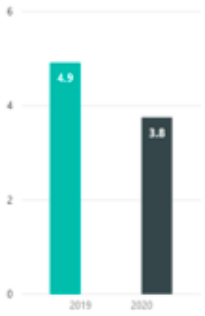
Mean Ventilator Days (VLBW)



Total Inborn VLBW pts

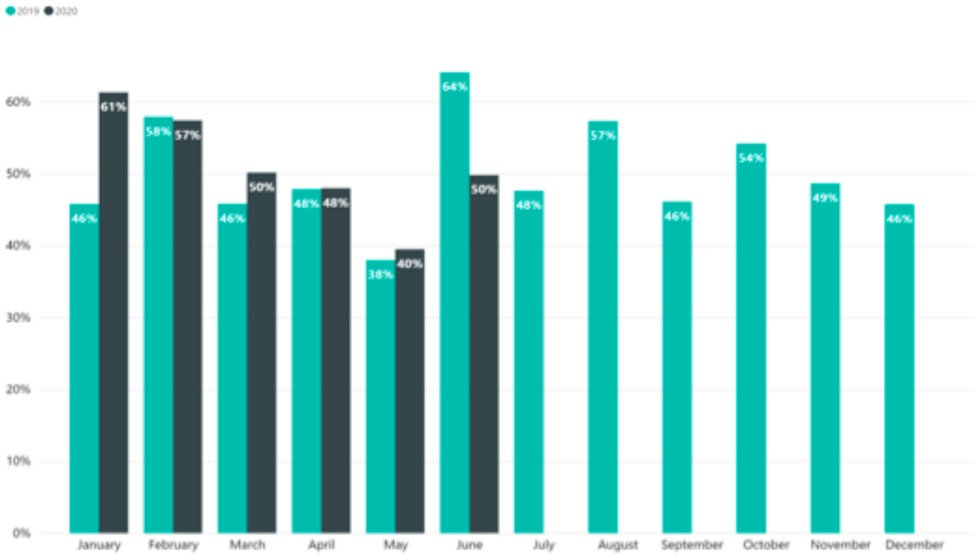
Month	2019	2020
January	121	156
February	113	120
March	136	105
April	129	106
May	115	139
June	132	162
July	158	
August	158	
September	144	
October	146	
November	135	
December	128	
Total	1615	788

Average by Year (Jan - Ju...



Neonatal Data - 2019-2020

Antenatal Steroid Administration - LPI



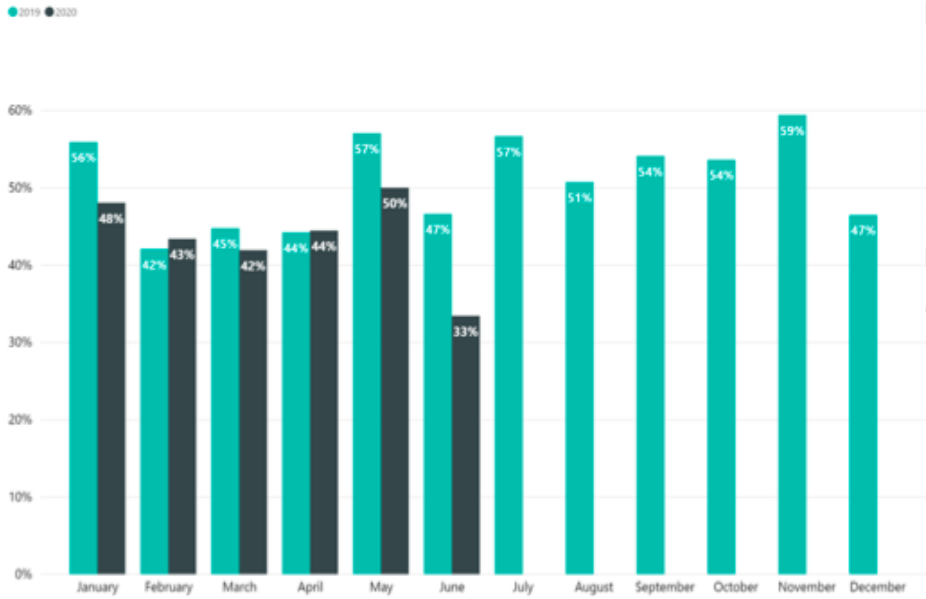
Total LPI Neonates

Month	2019	2020
January	315	347
February	337	378
March	338	348
April	346	344
May	278	312
June	342	380
July	391	
August	396	
September	366	
October	390	
November	381	
December	384	
Total	4264	2109

Average for Year (Jan - Jun)

Neonatal Data - 2019-2020

Antenatal Steroid Administration (VLBW)



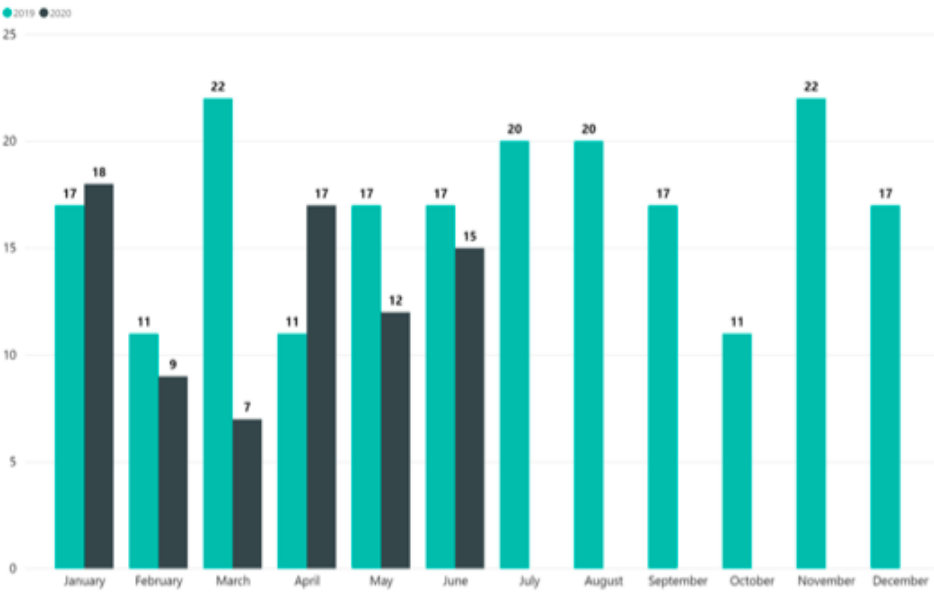
Total Inborn VLBW Neonates

Month	2019	2020
January	121	156
February	112	120
March	136	105
April	129	106
May	115	139
June	132	162
July	158	
August	158	
September	144	
October	146	
November	135	
December	128	
Total	1614	788

Average for Year (Jan - Jun)

Neonatal Data - 2019-2020

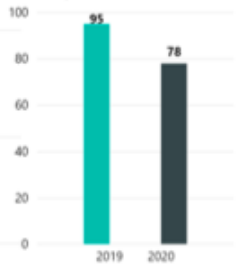
VLBW Transfers Out

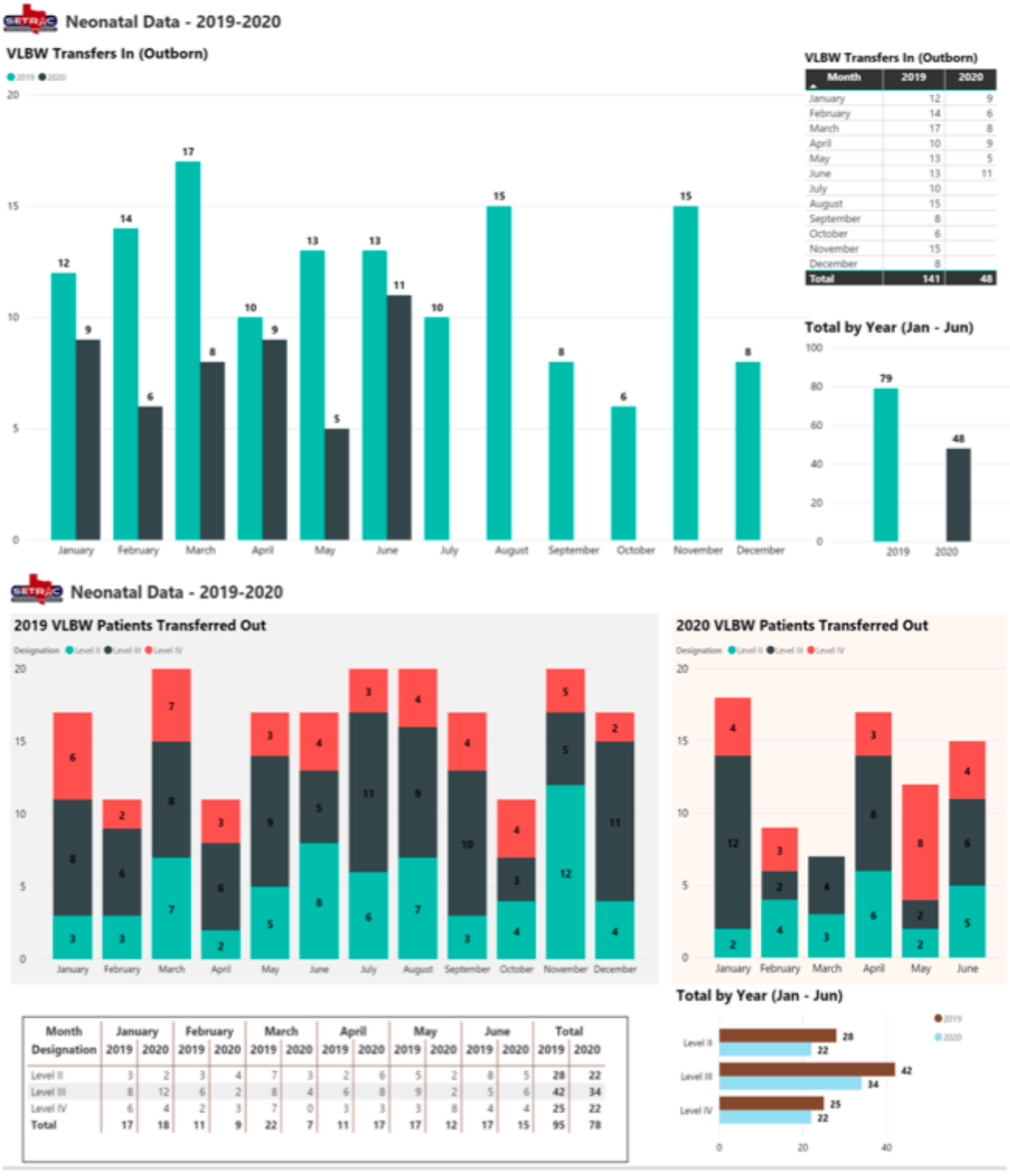


VLBW Transfers Out

Month	2019	2020
January	17	18
February	11	9
March	22	7
April	11	17
May	17	12
June	17	15
July	20	
August	20	
September	17	
October	11	
November	22	
December	17	
Total	202	78

Total by Year (Jan - Jun)





Month	January		February		March		April		May		June		Total	
Designation	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020
Level II	3	2	3	4	7	3	2	6	5	2	8	5	28	22
Level III	8	12	6	2	8	4	6	8	9	2	5	6	42	34
Level IV	6	4	2	3	7	0	3	3	3	8	4	4	25	22
Total	17	18	11	9	22	7	11	17	17	12	17	15	95	78

SETRAC Perinatal: Low Birth Weight infant morbidity workgroup

Safe Sleep in the NICU and beyond Toolkit Project

- Sample NICU Policy
- Nursing/Provider Education Tools
- Family Education Tools
- Crib Cards
- Data Collection Tool
- References and links to video materials

SETRAC Perinatal: Perinatal Planning Workgroup

- Coordination of Regional PEMS Disaster Preparedness drills with Houston Area OEM
- Regional OEM NICU, Well Newborn, Maternal Bed Space Dashboard Project (with SETRAC Disaster Preparedness Committee)
- NRP for EMS Providers (2021, with Perinatal QI Workgroup)

Summary:

- Perinatal QI spearheaded by local Perinatal Care Regions and their collaborating hospital stakeholders can have immense impact on outcomes for mothers and neonates in Texas.
- The implementation of projects will be through the use of the "TCHMB/ RAC-PCR Alliance/ individual PCR/ hospital stakeholder/ bedside clinician AXIS" for successful organized and replicable implementation of statewide projects
- The importance of a STATEWIDE granular deidentified patient-based PERINATAL DATABASE cannot be understated. This database is an essential need to achieve verifiable and measurable improvements in care for mothers and babies in the State of Texas.

Questions/Answers/Comments

Who is responsible for maintaining the database? SETRAC has an established database and it is part of a collaborative. Each hospital has a designated data person and the data maintained by SETRAC is deidentified. The data is fed back to the hospitals.

As extensive as the data are, this is not a granular database for the total state. It would have to be more robust. This is not the patient-level data that is needed.

What about the other regions beyond these two? All regions are present during discussions and two other regions have started a temperature meeting at the RAC PCR alliance. There is a strong recognition that there is a need for a statewide database. A statewide expert database was formed. Recommendations would be made to the collaborative in March. They are meeting periodically and some with other states. It is a work in progress. There are numerous other projects going on in other RACs.

A statewide database is recommended in the following letter that will be discussed. The prematurity rate in blacks is much higher, demonstrating the need for looking at race and ethnicity. The temperature project has been modified to look at race and race-based differences.

The database looking at quality is important but also the need for cost savings and lives saved.

Deidentifying in a RAC if there are only two facilities has the effect of not deidentifying at all.

Each PAC meeting will have best practices brought for discussion.

5. PAC Recommendation Letter to DSHS on Proposed Rule Language Changes Previously Discussed

DSHS is looking for the PAC to provide a letter of recommendation on the topics we have discussed in previous meetings related to SB 749.

PAC members were asked for comments to consolidate into a final document to be provided to DSHS.

Main items for discussion

1. SB 749 item- Telemedicine
2. SB 749 item- Gestational Age
3. SB 749 item- Waivers
4. SB 749 item- Appeals process
5. Echocardiography rule language revision
6. Advanced Cardiovascular Life Support (ACLS) rule language revision
7. Board Certification consistency

SB 749 item – Telemedicine - PAC members to provide guidance.

As per comments during meeting:

- We need to determine what complex maternal or neonatal patients need consultation on site vs when telemedicine can be used.
- PAC discussed ACOG and AAP recommendations for telemedicine and how to modify to make appropriate for Texas needs.
- MFM should be involved in drills, etc., to maintain teamwork approach.
- QAPI process to monitor timing of response from "an urgent request" (with facility defining this term for their community needs).
- Suggestion from Baptist to include genetic and metabolic specialists.

Per ACOG:

- MFM for consultation via telemedicine -

  - Level I - no mention of telemedicine
  - Level II - MFM readily available at all times for consultation on site, by phone or by telemedicine, as needed.
  - Level III - MFM with inpatient privileges readily available at all times, either onsite, by phone, or by telemedicine. Timing of need to be onsite is directed by urgency of clinical situation. However, MFM must be able to be onsite to provide direct care on site within 24 hrs.
  - Level IV - MFM with full inpatient privileges and co-management (No mention of telemedicine for MFM beyond Level III allowances.)
- Other specialists for consultation via telemedicine not discussed–
  - Level III - Full complement of subspecialists (critical care, general surgery, infectious disease, hematology, cardiology, nephrology, neurology, gastroenterology, internal medicine, behavioral health, and neonatology), readily available for inpatient consultation at all times
  - Level IV - Same plus: at least one on site of the following: neurosurgery, cardiac surgery, or transplant, readily available for inpatient consultation at all times. If the facility does not have all three subspecialties available, there should be a process in place to transfer women to a facility that can provide the needed service.

Per AAP:

- Level I, II - No mention of telemedicine.
- Level III A broad range of pediatric medical subspecialists and surgical specialists should be readily accessible on site or by prearranged consultative agreements. Prearranged consultative agreements can be performed by using telemedicine technology and/or telephone consultation, for example from a distant location. Pediatric ophthalmology services and an organized program for the monitoring, treatment and follow-up of retinopathy of prematurity should be readily available in level III facilities.
- Level IV "full range of pediatric medical and surgical pediatric subspecialists at the site". No mention of telemedicine.

We have since received written testimony from Texas ACOG regarding Level III MFM rules revision, requesting:

RULE §133.208 Maternal Designation Level III (d) (5):
(5) Maternal Fetal Medicine physician with inpatient privileges shall be available at all times for consultation and arrive at the patient bedside within 30 minutes of an urgent request to co-manage patients.

**********ADDING**********

(a) If telemedicine is utilized for maternal fetal medicine co-management, the facility shall have:
(i) a written plan for the appropriate use of telemedicine in the hospital that is compliant with the Telehealth and Telemedicine as per the Texas Medical Board and Texas Occupations Code
(ii) A process for informed consent and agreement from the patient for this modality
(iii) the maternal fetal medicine physician has in-patient privileges at the facility, regularly participates in the on-site care of patients at the facility, has access to the patient's medical records, and participates in the QAPI process of the facility's maternal program
(iv) a process that monitors the processes and outcomes of the maternal telemedicine encounters

PAC Recommendation: TBD at the 11/17/2020 PAC meeting
Previous discussion has been included in the above telemedicine discussion. Language was added after feedback was received.

Discussion of recommendation.
From a neonatologist perspective, telemedicine recommendation makes sense.

Access to the patient's record may not be feasible because of the numerous EMRs.

Access to patient medical record is related to critically ill patients and available within 30 minutes at the patient's bed side. Zoom and other interfaces make this easier to accomplish than in the past.

We have to make sure Zoom is HIPAA compliant.

Levels one and two do not require telemedicine. At a system level, Maternal-Fetal Medicine (MFM) makes it likely that this is for urban areas.

There are plenty of level three hospitals outside urban areas.

We are talking about critical care patients.

Co-management of telemedicine with MFM and ICU is important.
In order to provide support to level threes, neonatology then privileging would be required.

Consensus statement is to support ACOG recommendations for threes and fours and leave the twos and ones the same.

Audio-only discussion should be considered. Expansion to medically underserved often involves digital deserts.

The Value-Based Quality Improvement Committee recommended audio-only in some circumstances.

Telemedicine already specifies any electronic device that includes audio-only. We do not have to define this.

Medicaid was not reimbursing for audio-only and that is why this is an issue.

Women are dying at a very high rate and audio-only should not be the standard of care for prenatal care.

This is being used to increase access to care and not replace current practices.

Telephone only has its limits, but it has a role in emergencies.

HHSC Medicaid has been working with HMOs to address the technology gap.

There is presently no telemedicine discussed for subspecialists and so with no comment, this will not be changed.

Pediatric Discussion.
AAP recommendations are consistent with what the maternal recommendations provide.

Prearranged agreement with subspecialists should occur.

It is reasonable that they be credentialed and if not, at least some kind of agreement made.

Telemedicine can be a different kind of credentialing.

We recommend the quality initiative be used as well.

These comments will be word-smithed and re-presented to the PAC.

SB 749 item- gestational age
PAC members: discuss if we should wait until after data is available for review to assess the impact of the current rules in neonatal and maternal morbidity prior to making any new rule changes. We do not know the current impact of the rules.

PAC Recommendation: We recommend a statewide database, as data is needed in order to reach an evidence-based consensus on gestation age.

Gestational age will not be discussed today. The focus is on quality care. The state has asked to make a comment on gestational age. There are some on the council who disagree with this approach.

SB 749 item- Waivers

A consideration of waivers for facilities who did not obtain the level of care designation for which they applied, or for facilities in a geographic area of need.

PAC Recommendation: We must maintain quality in the care of our Texas mothers and babies, while allowing for appropriate access to high quality care.

SB 749 item- Appeals process

For fairness of the process and efficiency of completion, SB 749 mandates a 3-person panel to review each hospital's appeal. (HHSC person, DSHS person and a public member)

PAC Recommendation: DSHS to define the actual appeals process and allow for transparency of the process by including this detail posted on their website.

Other - Echocardiography discussion – language review from the rules
133.188, (10), C
Pediatric echocardiography with pediatric cardiology interpretation and consultation within one hour of an urgent request.

PAC Recommendation: We recommend a rules revision stating, "Pediatric echocardiography with pediatric cardiology interpretation and consultation within *four hours* of an urgent request."

We have to make a change if one hour is unreasonable.

Other – American Red Cross letter to PAC

Revise rule language regarding Advanced Cardiovascular Life Support (ACLS) to include the resuscitation course offered by the American Red Cross in addition to the one offered by the American Heart Association.

The AAP had no specific recommendations in this regard (resuscitation). This topic will be revisited. It is American Heart Association and the AAP.

Also Recognized resuscitation courses was added.

PAC Recommendation: We recommend revising this rule to allow for any resuscitation course provided by a nationally accredited organization.

807 BRAZOS ST, SUITE 607, AUSTIN, TX 78701 TEL: 512-708-8424, WWW.THBI.COM

Board Certification consistency
We received written testimony and verbal testimony from the Texas ACOG and PAC members regarding the need to have improved consistency regarding board certification of members of the maternal care team.

This puts a large burden on level fours and the length of time it takes for board certification. Legal review can be used to ensure consistency with the law and board of Ob/Gyn. This does not compromise the quality of care.

PAC Recommendation: We recommend the following changes to the rules document.

Level II and Level III Maternal Designation to be modified to include MFMs who are board eligible – For Level II, A board certified or board eligible maternal fetal medicine physician shall be available at all times for consultation. For Level III, A board certified or board eligible Maternal Fetal Medicine physician with inpatient privileges shall be available at all times for consultation and arrive at the patient bedside within 30 minutes of an urgent request to co-manage patients.

Level III and Level IV Maternal Designation (**RULE §133.209 Maternal Designation Level IV (d) (13) (C)**) to be modified to include anesthesiologists with board eligible status - A board certified or board eligible anesthesiologist with training and/or experience in obstetric anesthesia, including critically ill obstetric patients available for consultation at all times, and arrive at the patient bedside within 30 minutes for urgent requests

Level IV Maternal Designation **(RULE §133.209 Maternal Designation Level IV (d) (3))** to be modified to include OB/Gyns with board eligible status - A board certified or board eligible obstetrics and gynecology physician with maternal privileges shall be on-site at all times and available for urgent situations.

Wording change was made for Ob/Gyn and other certification and taken from Texas ACOG recommendation. Word-smithing will happen later. Clarification was made related to board eligible. We could always remove board certification from maternal side also if there is a concern that the rules mirror each other.

"Board eligible" would allow for expansion of providers due to delays related to COVID-19.

Stakeholder input resulted in a suggested change. There is no specific timeline for when the letter is due. The rule will take a year or so to change after the letter is drafted.

MOTION: *Approve the recommendations and edits and authorize the Chair to finalize the letter before sending it on to DSHS for review - prevailed.*

6. Public Comment.

Jonathan Nedrelow, Cook Children's Medical Center, stated that the current interpretation related to echocardiogram is too short a time period, as was discussed by the group earlier. There is the need for a measurable timeframe and four hours seems reasonable from the request to when the notes are added to the chart. Perhaps change the time requirement to reference the request time to the start of the echo being one hour.

Dr. Savany, commented on telemedicine and stated that the documentation required was not included in the recommendation. FPPE and OPPE the credentialing is done by the providing hospital under telemedicine. He supported the idea that interpretation of the echocardiogram as soon as possible. Language would have to be added for board eligible for level four facilities.

There was one written comment sent in from Lisa Hutchens, HCA Health Care, stating that they were requesting changing the leveling survey requirement. This is supported by the American Heart Association and the American Red Cross related to CPR and resuscitation programs.

7. Adjourn. There being no further business, the meeting was adjourned.

***